SUBMIT COMPLETED FORM TO YOUR DEPARTMENT PERSONNEL AND/OR ATTENDANCE CLERK.

STATE OF CALIFORNIA **GROUP LEGAL SERVICES INSURANCE PLAN**

Underwritten by GuideOne Insurance, West Des Moines, IA.

Do not send to DPA

No money needed to enroll — Payroll deduction.

Gp.	numb	oer:	1020	2

SECTION A. Please t	ype or complete in b	alipoint pen. See priva	y notice on back side.				
1. Type of Action (C	heckonel	one) 2. Social Security Number	4. Name in Full				
		ar Security Number	First	Middle Initial . Last			
NEW ENROLL Complete section							
A (I-6) and B (I		######################################	5. Mailing Address	Application of the control of the co			
b. D. CHANGE OF	COVERAGE -	\$274.64	Number and Street	And the second of the second o			
Complete section	MS : 122 12 12 12 12 12 12 12 12 12 12 12 12	3 Date of Birth Month Day Year	TATING COMMANDER				
A (1-6) and B (1	183	Day real specimen	en e				
c. 🔲 CANCEL COV	'ERAGE+	######################################	City	State ZIP Code			
Complete section A (1-6) and B (2	ONS PACE BOD	y de legar (TO THE CONTROL OF THE	te territorio, especial plus temps de production production production de la reconstrucción d			
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2	- 201-11-10-10		7	Contract on the American de State of the Sta			
SECTION B. Please c	heck appropriate box	r, read and sign.					
1 Authorize d	ledi ictions to be made f	rom my salany to cover m	v chara of annoliment in the	States Group Legal Services Insurance Plan			
as it is now o	or as it may be in the fu	ture with coverage as sho	wn below	States Story Legal Services in Bulletine (Fig. 1)			
as it is now or as it may be in the future with coverage as shown below. Please check type of coverage to be elected and monthly premium amount (check one only):							
	· · · · · · · · · · · · · · · · · · ·			[] T. S			
	ividual \$9.60/mon	h c∟ Domestic p \$16.95/mo		partner, and/or domestic partnership			
b. Fam	nily \$16.95/month	*must provid	le a copy of the domestic pa	artner certification (if not already on file in the			
		<u>employee's</u>	personnel file)	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			
If you selected family	y coverage, please list s	oouse/domestic partner a	nd unmarried dependent d	niforen below.			
Name		Date of Birth	Name	Date of Birth			
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2 a lefect to cand	cel the Services Insurance Plan	b. Reason for cancella (optional)	tion:				
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23.25.(23) (23) (23) (24) (25) (25) (25) (25) (25) (25) (25) (25		######################################	THE STATE OF THE S				
3. Please read and sign	1	1 T	CALLES AND				
Application is hereby	made for coverage as inc	licated above, for all persor	s:::::::::::::::::::::::::::::::::::::	application for benefits through GuideOne Insurance;			
listed hereon; subject	to all terms and conditio	ns of the contract for whic	n – I hereby authorize my En	nployer as my agent to deduct the cost to me for such			
		of become effective until the dat this application and that if if		s it may be in the future, from my wages or salary within effective date for the coverage I am electing I further			
application is not approv	red, the amount of any pre-	nium sübmitted herewith will b	e understand the premiums s	shown above include an administrative cost incurred by the			
	hat all information entered is the coverage for which I am an	rue. I fully understand the waitin	g State, which may be increas	ed without prior notice:			
	U.C. COVERIGE HOI-WIRE REPRESENTATION		urujan kuristeridi arti pipisetang bandusta kit apada pinang temparang ang mpakitabahan kipada	A first entropy of the first entropy of the first of the			
~				Month Day Year			
Signature 🔼				Date / / /			
SECTION C. To be se	mpleted by agency	personnel office. Note (his section is audited by	500			
SECTION C. TO be co	unbiered ny sideuch t	el-sonner office. Note t	ms section is addited by	3GO.			
1. Deduction code	2. Organization code	3. Deduction amount	4. Agency name	5. Date received in employing office			
075	001	(Circle one)		Month Day Year			
075	081	\$9.60 or \$16.95		/_/			
6. Bargaining Unit #	7 . Agency code	8 . Rept. unit code	12. AUTHORIZED AGENO				
				for payroll deductions signed by this employee and appointin by or organization as his/her agent is on file in this office.			
	100 May 200 Ma		are as are named compan	9 gar manager and comment and an in a 10 mg and a 100 mg and a 1			
9. Remarks—For newly eligib	ie employee/status change(s). 1	Permitting event date Month Day Year Ye		Telephone () –			
2. P. L. & M. S. & A.	# # # # # # # # # # # # # # # # # # #	Month Day Year		(indicate if CALNET or give area code)			
■■ CDRoom shock if D	larmanant	1 1	12 Effective data of				
I 1. Please check if Permanent 13. Effective date of coverage Intermittent Employee (applies to active State employees only). Month , Day , Year							
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